General Assembly

Amendment

January Session, 2015

LCO No. **6550**

Offered by:
SEN. LOONEY, 11th Dist.
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To: Senate Bill No. **808** File No. 438 Cal. No. 271

"AN ACT CONCERNING THE ESTABLISHMENT OF A DISPUTE RESOLUTION PROCESS FOR SURPRISE BILLS AND BILLS FOR EMERGENCY SERVICES."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective January 1, 2016*) (a) As used in this section:

(1) "Emergency condition" means a medical condition, or a mental or nervous condition as set forth in sections 38a-488a and 38a-514 of the general statutes, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the individual afflicted with a medical condition in serious jeopardy, or in the case of an individual afflicted with a mental or nervous condition, placing the health of such

individual or others in serious jeopardy, (B) serious impairment to such individual's bodily functions, (C) serious dysfunction of any bodily organ or body part of such individual, (D) serious disfigurement of such individual, or (E) a condition described in Section 1867 (e)(1)(A) of the Social Security Act, as amended from time to time;

(2) "Emergency services" means, with respect to an emergency condition, (A) a medical screening examination as required under Section 1867 of the Social Security Act, as amended from time to time, that is within the capability of a hospital emergency department, including ancillary services routinely available to such department to evaluate such condition, and (B) such further medical examinations and treatment required under said Section 1867 to stabilize such individual, that are within the capability of the hospital staff and facilities;

(3) "Health care plan" means an individual or a group health insurance policy or health benefit plan that provides coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes;

(4) "Health care provider" means an individual licensed to provide health care services under chapters 370 to 373, inclusive, of the general statutes, chapters 375 to 383b, inclusive, of the general statutes, and chapters 384a to 384c, inclusive, of the general statutes;

(5) "Health carrier" means an insurance company, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that delivers, issues for delivery, renews, amends or continues a health care plan in this state;

(6) (A) "Surprise bill" means a bill for health care services, other than emergency services, received by an insured for services rendered by an out-of-network health care provider, where:

(i) (I) An in-network health care provider was unavailable at the time such services were rendered to such insured, (II) an out-of-network health care provider rendered such services without the insured's knowledge of such provider's network status, or (III) unforeseen additional services were medically required at the time the health care services were rendered; or

(ii) Such services were referred to such out-of-network provider by an in-network health care provider without the written consent of the insured explicitly acknowledging (I) such referral to an out-of-network health care provider, and (II) that the referral may result in costs not covered by the insured's health care plan.

(B) "Surprise bill" does not include a bill for health care services received by an insured when an in-network health care provider was available to render such services and the insured knowingly elected to obtain such services from another health care provider who was out-of-network.

(C) A referral occurs when (i) an out-of-network health care provider renders health care services to an insured in an in-network health care provider's office or facility during the course of the same visit, (ii) an in-network health care provider sends a specimen taken from the insured in such provider's office to an out-of-network health care provider or an out-of-network laboratory or other out-of-network facility, or (iii) an insured's health care plan requires a referral for a health care service and an out-of-network health care provider renders such service to the insured.

(b) (1) No health carrier shall require prior authorization for rendering emergency services to an insured.

(2) No health carrier shall impose, for emergency services rendered to an insured by an out-of-network health care provider, a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other

out-of-pocket expense that would be imposed if such emergency services were rendered by an in-network health care provider.

(3) If emergency services were rendered to an insured by an out-of-network health care provider, the health carrier shall reimburse such provider the greatest of the following amounts: (A) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (B) the usual, customary and reasonable rate for such services as determined by the health carrier; or (C) the amount Medicare would reimburse for such services.

(c) If health care services were rendered to an insured by an out-of-network health care provider and the health carrier failed to inform such insured, if such insured was required to be informed, of the network status of such health care provider pursuant to subdivision (3) of subsection (d) of section 38a-591b of the general statutes, as amended by this act, the health carrier shall not impose a coinsurance, copayment, deductible or other out-of-pocket expense that is greater than the coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed if such services were rendered by an in-network health care provider.

(d) If a health carrier receives a claim by an out-of-network health care provider for health care services rendered to an insured and such claim is or could be a surprise bill, the health carrier shall include a notice in or with the explanation of benefits provided to the insured for such claim. Such notice shall (1) advise the insured that the claim is or could be a surprise bill, (2) advise the insured that the insured should contact the health carrier or visit the health carrier's Internet web site for more information, and (3) provide a phone number and Internet web site address for such purpose.

(e) The Insurance Commissioner and the Commissioner of Public Health shall jointly adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish a dispute

resolution process by which a dispute over a bill for emergency services or a surprise bill may be resolved. Such regulations shall include, but need not be limited to, (1) the procedures and standards for such dispute resolution process, (2) the procedures and standards for certifying independent dispute resolution entities, (3) the criteria to be used by independent dispute resolution entities to determine a reasonable fee for health care services or emergency services, and (4) the fees for and payment of such independent dispute resolution entities.

Sec. 2. (NEW) (*Effective January 1, 2016*) (a) Each health care provider, as defined in section 1 of this act, shall, at the time such provider schedules an admission, service or procedure for a patient, other than for emergency services as defined in section 1 of this act, determine whether such patient is covered under a health insurance policy. If such provider determines that such patient is covered under a health insurance policy, such provider shall notify such patient, in writing, whether such provider is in-network or out-of-network under such policy.

(b) If a health care provider determines under subsection (a) of this section that a patient is uninsured or that such provider is out-of-network under a patient's health insurance policy, such provider shall notify the patient, in writing, prior to the provision of the admission, service or procedure, (1) of the actual charges for the admission, service or procedure, (2) that such patient may be charged for, and is responsible for payment of, any unforeseen additional services or procedures that arise from such admission, service or procedure, and (3) if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy will apply.

(c) If a health care provider who is out-of-network under a patient's health insurance policy fails to provide the notices required under

subsections (a) and (b) of this section to such patient, such patient shall only be required to pay the coinsurance, copayment, deductible or other out-of-pocket expense that would be required from such patient if such admission, service or procedure was provided by an in-network health care provider and such health care provider shall accept reimbursement for such admission, service or procedure at the in-network rate under such health insurance policy.

Sec. 3. Subsection (d) of section 38a-591b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(d) Each health carrier shall:

(1) Include in the insurance policy, certificate of coverage or handbook provided to covered persons a clear and comprehensive description of:

(A) Its utilization review and benefit determination procedures;

(B) Its grievance procedures, including the grievance procedures for requesting a review of an adverse determination;

(C) A description of the external review procedures set forth in section 38a-591g, in a format prescribed by the commissioner and including a statement that discloses that:

(i) A covered person may file a request for an external review of an adverse determination or a final adverse determination with the commissioner and that such review is available when the adverse determination or the final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. Such disclosure shall include the contact information of the commissioner; and

(ii) When filing a request for an external review of an adverse determination or a final adverse determination, the covered person

shall be required to authorize the release of any medical records that may be required to be reviewed for the purpose of making a decision on such request;

(D) A statement of the rights and responsibilities of covered persons with respect to each of the procedures under subparagraphs (A) to (C), inclusive, of this subdivision. Such statement shall include a disclosure that a covered person has the right to contact the commissioner's office or the Office of Healthcare Advocate at any time for assistance and shall include the contact information for said offices;

(E) A description of what constitutes a surprise bill, as defined in subsection (a) of section 1 of this act;

(2) Inform its covered persons, at the time of initial enrollment and at least annually thereafter, of its grievance procedures. This requirement may be fulfilled by including such procedures in an enrollment agreement or update to such agreement;

(3) Inform a covered person or the covered person's health care professional, as applicable, at the time the covered person or the covered person's health care professional requests a prospective or concurrent review: (A) The network status under such covered person's health benefit plan of the health care professional who will be providing the health care service or course of treatment; (B) the amount the health carrier will reimburse such health care professional for such service or treatment; and (C) how such amount compares to the usual, customary and reasonable charge, as determined by the Centers for Medicare & Medicaid Services, for such service or treatment;

[(3)**]** (4) Inform a covered person and the covered person's health care professional of the health carrier's grievance procedures whenever the health carrier denies certification of a benefit requested by a covered person's health care professional;

(5) Prominently post on its Internet web site the description required under subparagraph (E) of subdivision (1) of this subsection;

[(4)**]** (6) Include in materials intended for prospective covered persons a summary of its utilization review and benefit determination procedures;

[(5)**]** (7) Print on its membership or identification cards a toll-free telephone number for utilization review and benefit determinations;

[(6)**]** (8) Maintain records of all benefit requests, claims and notices associated with utilization review and benefit determinations made in accordance with section 38a-591d for not less than six years after such requests, claims and notices were made. Each health carrier shall make such records available for examination by the commissioner and appropriate federal oversight agencies upon request; and

[(7)**]** (9) Maintain records in accordance with section 38a-591h of all grievances received. Each health carrier shall make such records available for examination by covered persons, to the extent such records are permitted to be disclosed by law, the commissioner and appropriate federal oversight agencies upon request.

Sec. 4. Section 20-7f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

(a) For purposes of this section:

(1) "Request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "This is not a bill".

(2) "Health care provider" means a person licensed to provide health care services under chapters 370 to 373, inclusive, chapters 375 to 383b, inclusive, chapters 384a to 384c, inclusive, or chapter 400j.

(3) "Enrollee" means a person who has contracted for or who participates in a **[**managed**]** health care plan for **[**himself or his**]** such enrollee or such enrollee's eligible dependents.

[(4) "Managed care organization" means an insurer, health care center, hospital or medical service corporation or other organization delivering, issuing for delivery, renewing or amending any individual or group health managed care plan in this state.**]**

[(5) "Copayment or deductible"**]** (4) "Coinsurance, copayment, deductible or other out-of-pocket expense" means the portion of a charge for services covered by a **[**managed**]** health care plan that, under the plan's terms, it is the obligation of the enrollee to pay.

(5) "Health care plan" has the same meaning as provided in subsection (a) of section 1 of this act.

(6) "Health carrier" has the same meaning as provided in subsection (a) of section 1 of this act.

(7) "Emergency services" has the same meaning as provided in subsection (a) of section 1 of this act.

(b) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to request payment from an enrollee, other than a coinsurance, copayment, **[**or**]** deductible or other out-of-pocket expense, for **[**medical**]** (1) health care services covered under a **[**managed**]** health care plan, (2) emergency services covered under a health care plan and rendered by an out-of-network health care provider, or (3) health care services rendered by an out-of-network health care provider where the enrollee did not receive the notices required under subsections (a) and (b) of section 2 of this act.

(c) It shall be an unfair trade practice in violation of chapter 735a for any health care provider to report to a credit reporting agency an enrollee's failure to pay a bill for **[**medical**]** health care services when a

[managed care organization**]** health carrier has primary responsibility for payment of such services.

Sec. 5. Section 38a-478d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2015*):

For any contract delivered, issued for delivery, renewed, amended or continued in this state, each managed care organization shall:

(1) Provide at least annually to each enrollee a listing of all providers available under the provisions of the enrollee's enrollment agreement, in writing or through the Internet at the option of the enrollee;

(2) Provide notification to each enrollee of the termination or withdrawal of a provider who was available under the provisions of the enrollee's enrollment agreement, in writing or through the Internet at the option of the enrollee. Such notification shall be provided as soon as possible but not later than thirty days after such termination or withdrawal;

[(2)**]** (3) Include, under a separate category or heading, participating advanced practice registered nurses in the listing of providers specified under subdivision (1) of this section; and

[(3)**]** (4) For a managed care plan that requires the selection of a primary care provider, **[**: (A) Allow**]** allow an enrollee to designate a participating, in-network physician or a participating, in-network advanced practice registered nurse as such enrollee's primary care provider. **[**; and

(B) Provide notification, as soon as possible, to each such enrollee upon the termination or withdrawal of the enrollee's primary care provider.**]**"

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2016*	New section
Sec. 2	*January 1, 2016*	New section
Sec. 3	*October 1, 2015*	38a-591b(d)
Sec. 4	*October 1, 2015*	20-7f
Sec. 5	*October 1, 2015*	38a-478d